"Can you go back to work?"

Family physicians' experiences with assessing patients' functional ability to return to work

Sophie Soklaridis PhD **Grace Tang** **Carrie Cartmill** MHSc **J. David Cassidy** PhD DrMedSc **Joel Andersen** MD MSc

Abstract

Objective To explore the challenges academic FPs face when assessing patients' functional ability to return to work; to produce a detailed account of FPs' experiences and views on workplace disability management; to describe which parts of the disability assessment and management process FPs would like to modify or relinquish; and to provide solutions to streamline the overall process of assessing disability.

Design Qualitative phenomenologic study using in-depth interviews.

Setting A family health team located in a large urban teaching hospital in Toronto, Ont.

Participants Purposive sample of 6 FPs.

Methods Participants were invited to participate in 1-hour, in-depth interviews. Themes were derived from qualitative analysis of the data using a phenomenologic approach.

Main findings Four themes emerged from the interviews: the FP's role in filing a compensation claim; the complexity of the patient; the FP's lack of training in occupational health; and possible solutions to improve the process of assessing the functional ability of an injured worker.

Conclusion As in other areas of medicine, the role of the FP is to restore health; optimize social, psychological, and functional capabilities; and minimize the negative effects of injury. Assessing functional abilities for return to work can be challenging, as FPs are trained to focus on assessing and treating symptoms rather than on determining occupational functioning. Functional assessment forms do not provide enough information for physicians and serve as a poor communication tool among the stakeholders involved with returning an injured worker to work.

EDITOR'S KEY POINTS

- Physicians are traditionally considered to be legitimate gatekeepers of the return-to-work process for patients who have suffered work-related illnesses or injuries.
- A study of GPs in the United Kingdom revealed that the burden of providing sickness certificates was so onerous that half of the GPs who participated in the study indicated that they wished their role in certification were taken away. According to the literature, factors contributing to the difficulty of this issue for physicians include time constraints, insufficient educational opportunities about occupational health issues, possible conflicts with their role as their patients' advocates, and the complex nature of the physician-patient relationship.
- This qualitative study explores the challenges FPs face when asked to assess patients' functional ability to return to work, produces a detailed account of FPs' experiences and views on workplace disability management, and provides solutions to streamline the structure and overall process of assessing disability.

This article has been peer reviewed.
Can Fam Physician 2011;57:202-9

« Pouvez-vous retourner travailler? »

Expérience qu'ont les médecins de famille de l'évaluation de la capacité de retour au travail

Sophie Soklaridis PhD **Grace Tang** **Carrie Cartmill** MHSc **J. David Cassidy** PhD DrMedSc **Joel Andersen** MD MSc

Résumé

Objectif Examiner les défis rencontrés par des MF universitaires lorsqu'ils évaluent la capacité de retour au travail de leurs patients; faire un compte rendu détaillé de leur expérience et de leur opinion sur la gestion de l'incapacité au travail; préciser quelles parties de l'évaluation et du processus de traitement de l'incapacité ils souhaiteraient modifier ou abandonner; et suggérer des solutions pour rationaliser l'ensemble du processus d'évaluation de l'incapacité.

Type d'étude Étude phénoménologique qualitative à l'aide d'entrevues en profondeur

Contexte Une équipe de santé familiale située dans un grand hôpital d'enseignement urbain à Toronto, Ontario.

Participants Un échantillon raisonné de 6 MF.

Méthodes On a demandé aux MF de participer à des entrevues en profondeur d'une heure. Les thèmes ont été extraits à partir d'une analyse qualitative des données qui utilisait une approche phénoménologique.

Principales observations Quatre thèmes sont ressortis des entrevues : le rôle du médecin lorsqu'il rédige une demande d'indemnisation; la complexité du patient; le manque de formation du MF en santé au travail; et les solutions éventuelles pour améliorer le processus d'évaluation de la capacité fonctionnelle d'un accidenté du travail.

Conclusion Comme dans les autres domaines de la médecine, le rôle du MF est de rétablir la santé; optimiser les capacités sociales, psychologiques et fonctionnelles; et minimiser les effets négatifs de la blessure. L'évaluation de la capacité de retour au travail peut constituer un défi, puisque le MF est d'abord formé pour évaluer et traiter des symptômes plutôt que pour déterminer une capacité au travail. Les formulaires d'évaluation fonctionnelle ne fournissent pas assez d'information au médecin et ne sont pas des outils de communication vraiment utiles aux diverses instances qui s'occupent de retourner un travailleur blessé au travail.

POINTS DE REPÈRE DU RÉDACTEUR

- On a l'habitude de penser que les médecins de famille (MF) sont des responsables légitimes du processus de retour au travail des patients qui ont eu une maladie ou une blessure liée au travail.
- Une étude chez des MF du Royaume Uni a révélé que la tâche de rédiger des certificats de maladie était si lourde que la moitié des MF participant à l'étude souhaitaient qu'on les exempte de cette tâche. D'après la littérature, les facteurs qui contribuent à rendre cette tâche difficile incluent les contraintes de temps, le peu d'occasions de formation sur les questions de santé au travail, les conflits éventuels avec leur rôle de défenseur de leur patient et la nature complexe de la relation médecin-patient.
- Cette étude qualitative explore les défis auxquels font face les MF lorsqu'on leur demande d'évaluer la capacité fonctionnelle de retour au travail de leurs patients; décrit en détails l'expérience et les opinions des MF concernant la gestion de l'incapacité au travail; et suggère des solutions pour rationaliser la structure et le processus global d'évaluation de l'incapacité.

Cet article a fait l'objet d'une révision par des pairs.
Can Fam Physician 2011;57:202-9

Family physicians are seen as having an important role in the return-to-work (RTW) process. Research has shown that interactions between physicians and patients affect RTW outcomes.[1,2] The medical community has created policies and guidelines that outline the physician's involvement with RTW.[3-6] The physician's role is to provide medical treatment and guidance, and to provide information outlining patients' work restrictions or necessary accommodations.[7] Along with the traditional role of physicians as the gatekeepers in the RTW process, FPs are expected to provide medical justification for patients' receipt of compensation benefits, to give their opinion on how injuries or illnesses are related to patients' work, to determine the length of time workers should be off work, and to judge the appropriateness of temporary work reassignments.[2,7] However, the inherently complex nature of the RTW process makes implementation of these policies and guidelines difficult. Other than the nature of injury and health care treatments, psychosocial factors such as workplace relationships,[8] economic factors such as secondary financial gain,[9] the compensation process and employer policies,[10] and social policies[11,12] all come into play in the RTW process.

The expectations that various stakeholders have of FPs are sometimes diverse and often contribute to the complexity of the FP's role.[7] There is increasing pressure on FPs, as governments seek to improve efficiency and increasingly perceive medical certification of illness to be contributing to poor economic performance.[13] Hussey et al revealed that the burden on GPs in the United Kingdom of providing sickness certificates was so onerous that half of the GPs who participated in the study wished their role in certification were taken away.[14] Other challenges that have been cited include inadequate knowledge or skills to provide impairment evaluation or opinion; concerns about trust, confidentiality, and symptom exaggeration by patients that could adversely affect management; time constraints[15,16]; lack of strategies for measurement of residual function; and differences between patient and physician values.[17]

This study focuses on academic FPs' experiences of assessing patients' functional ability to RTW in Ontario. Our research addresses the following objectives: to explore the challenges FPs face when asked to assess patients' functional ability to RTW; to produce a detailed account of FPs' experiences and views on workplace disability management, including which parts of the disability assessment and management process they would like to modify or relinquish; and to provide solutions to streamline the structure and overall process of assessing disability.

METHODS

Study design

A descriptive phenomenologic approach was used to collect data and inform the analysis of this study. Phenomenology has roots in the philosophical perspectives of Edmund Husserl (1859-1938), a German mathematician, who believed that the objectivism of science precluded an adequate comprehension of the world. The basic tenet of this approach is to describe particular phenomena, or the appearance of things, as lived experiences.[18] Lived experiences involve the immediate consciousness of life's events before reflection and without interpretation. It is this experience that gives meaning to each individual's perceptions of a particular phenomenon, and thus presents to the individual what is true or real in his or her life.[19]

For this study, 6 in-depth interviews were conducted with academic FPs from a family health team located within a large urban academic teaching hospital in Toronto, Ont. All FPs from the family health team who had experience with functional ability assessment and the disability management process were eligible to participate. Four respondents were women and 2 were men. Years of experience as a practising FP ranged from 4 to 29 years. All FPs held academic appointments from the academic teaching hospital's affiliated university.

In phenomenologic research, data are commonly collected through face-to-face interviews to gain insights into the experiences of the participants. Open-ended interviews facilitate the collection of rich data by providing participants with the opportunity to describe their experiences fully. The in-depth interviews were semistructured and followed an iterative process; questions were modified depending on the interviewees' responses. The topical area of how study participants experienced the process of assessing functional ability for RTW, however, remained the same throughout the interview process. The following questions were posed to elicit experiences with assessing the functional ability of injured workers:

1. What is it like having to assess a patient's functional ability?
2. How do you feel about having to assess a patient's functional ability?
3. Based on your experience, what part of the process would you like to modify or change?

Each interview lasted approximately 1 hour. The interviews were audiotaped and professionally transcribed. Recording of the sessions increased the accuracy of information gathering, as it allowed the interviewer to concentrate on the interview and its process rather than on attempting to take detailed notes during the interview.

In qualitative research, guidelines for determining nonprobabilistic sample sizes are virtually nonexistent. This study involved purposive sampling,[18,20] the rationale of which was to select information-rich cases that would illuminate the research questions being studied.[21] This is an appropriate method to select participants for a study using a descriptive phenomenologic approach because the aim is to understand and describe a particular

phenomenon from the perspective of those who have experienced it. Sample sizes of up to 10 are adequate, provided participants are able to provide rich descriptions of the phenomenon.[18] Given the narrow focus of the research question and our aim to describe the lived experiences of a few individuals, data saturation using our phenomenologic approach was not a goal,[22] and thus the sample size of 6 was deemed appropriate.[18]

Ethics

Approval from the hospital ethics review board was obtained for the study. At the beginning of each interview, the interviewer (G.T.) obtained both verbal confirmation of consent and written informed consent. Participating FPs were provided with signed copies of their consent forms at the beginning of the interviews.

Data analysis

We analyzed the descriptions given by participants and divided them into meaning-laden statements, a process known as *horizontalization.*[23] Then, we transformed them into clusters of meaning expressed in phenomenologic concepts. Finally, we tied the concepts together to make a general description of the experiences in 2 ways: the *textural description* of what was experienced and the *structural description* of how it was experienced.[24] The goal of this phenomenologic report was to leave the reader with the essence of the experience[23] and the belief that they "understand better what it is like for someone to experience [the phenomenon]."[25]

Following this process, 2 researchers (S.S. and G.T.) immersed themselves in the data by independently reading transcripts and field notes to identify principal elements. Coding was done using the constant comparative method,[26] moving back and forth between interview material and analysis and uncovering similarities and differences in data from the various interviews. This procedure generated categories and subcategories; emerging themes became the categories for analysis. Triangulation, by including a third coder (C.C.) for the final analysis, was used to improve the consistency and reliability of analyses.[27] Differences in interpretation were resolved by consensus. The final analysis involved examining all the data collectively, thus permitting relationships between and among central themes to emerge.

A qualitative computer software package, NVivo,[28] was used to store and organize the various codes derived from the data. The software allowed each code or theme to be stored and then organized into larger categories as the research proceeded.

FINDINGS

Four themes emerged from the interviews: the FP's role in filing compensation claims; the complexity of the patient; the FP's lack of training in occupational health; and possible solutions for improving the process of assessing the functional ability of an injured worker.

Role in filing compensation claims

Participating FPs experienced various logistical challenges to filling out the forms necessary to file compensation claims. Several FPs described how their patients discussed other health-related issues at appointments and how the forms and work-related injuries were often secondary to the visits. This provided FPs with very little or no time to complete forms for patients, as one FP described:

> It's very challenging because when patients [are] present ... they are coming because they are diabetic or they are coming because of hypertension, they are coming because they are needing a prescription renewal, [and] often you see the form [only as you] are finishing up the visit.

Some FPs described how their patients were often not forthcoming with whether their visits were for work-related injuries. In fact, one FP described how months went by before she realized that the patient was coming in for a work-related injury:

> People won't tell you it's a workplace injury at all; and then you go through the whole thing, and then like a month goes, 2, 3 months go by; you see them for every visit, you bill [the Ontario Health Insurance Plan] for all those visits, and then finally they say something and you're like, "I thought you told me that happened at home." Somebody told me they fell off their roof at home so I was, "Oh well." He had a broken leg and all this stuff and [it turned out] this happened at a construction site at work and he didn't tell me.

Many FPs concurred that patients often avoided discussing work injuries and underreported injuries because they did not want to be stigmatized and risk losing their jobs:

> I have had many people minimize their injuries and not want me to put in a compensation claim because they want to go back to work, and in this economy people don't want to be perceived as weak or damaged in some way. So I have ... been interested to see how many patients in fact don't want me ... to put this through as a [Workplace Safety and Insurance Board claim].

Overall, the seemingly simple task of filing a compensation claim had several logistical and administrative challenges.

Complexity of the patient

Logistical barriers aside, and as alluded to earlier, several FPs described their patients as "complex." Although FPs described such patients using a medical lens when referring to pre-existing conditions and special circumstances such as pregnancy, most participants used a psychosocial lens to describe why they perceived their patients to be complex. They cited workplace psychosocial factors as the main difficulty for returning patients to work:

> It's not the [musculoskeletal] things that I'm seeing. I'm seeing the patients who can't cope with their workplace environment and are developing anxiety and depression and need me to write sick notes for them because they have a conflict with either a co-worker or with a supervisor. So that's the bulk of what I see.

The FPs in this study agreed that patients who experienced despondency in their lives and their work tended to use "excuses" as a way of escaping their current realities. One FP observed the following:

> I see people [who] are desperately unhappy with their lives, and a work-related injury sometimes is an opportunity for them to get out of something that they are unhappy with .... And that's the hard type of patient to manage.

In addition, FPs described how pain was a subjective response, and oftentimes their objective examinations did not correspond with patients' responses:

> A patient might come in and they might be in a lot of pain, but when I'm doing the exam, they have full range of motion or they are able to do everything. So it's a little bit hard sometimes to assess that because my objective findings or their subjective feelings [are off, and] it's hard to assess their subjective pain.

A few FPs described experiencing challenges in situations in which there was the risk of secondary gain for patients. They described being unsure of their assessments:

> I never know if someone is lying to me or not lying to me. I never know if my assessment is true or not true, and I never know how to put people back to work in an appropriate time. I don't know if I should be pushing them to go back to work sooner or being slow and protracted; so I am really relying on the patient's word rather than anything else .... I had a recent one where there was a girl who got hurt; she worked at a retail store, and she said her pain is like horrible and she can't do anything [in the store or] in the office either. She could be a very good faker, which I'm not sure, or she could really be in a lot of pain. It's very hard for me to tell sometimes.

Another FP pointed out that most patients were honest about their abilities and thus easy to assess. However there was a small minority who might be malingering, which made the assessment process more difficult.

> Most of the patients don't lie .... But the problem is that [for some patients] I'm not sure of how much is real and how much is not real, and those people I have difficulty with because I'm not sure exactly [how to assess them].

Participants described the assessment process as a complex practice that needed to consider the various psychosocial factors that often accompany a work-related injury. As a result, the experience of filling out forms and assessing functional abilities was not necessarily a straightforward process.

Knowledge and skills required for assessment

All FPs described inadequate education on issues of occupational health during their medical training:

> In medical school for example, there is nothing about occupational health .... [M]aybe at that point there should be some kind of introduction in terms of functional ability assessment. In residency, as family medicine residency, there is nothing really there either in terms specifically geared to this [responsibility] or even that we are going to be faced with it.

As a result, most of the FPs did not feel confident when assessing functional abilities. They believed they were ill-equipped to make decisions about patients' ability to RTW. As one participant explained, "I have no question that I don't have the proper training to do the kind of detailed functional assessment that sometimes is necessary to really be able to determine when patients can go back [to work]."

Several FPs also described how they did not believe they had either the proper training or the tools necessary to identify patients who were malingering:

> I don't have any tools, so how the hell do I know if [the patient] can do it [lift 20 lb] or can't do it. Or even if they can do it but pretend not to [be able to] do it .... I have never been taught to be able to decipher between who is malingering and not malingering. There are a few tricks that you can use, but I don't know what they are.

The lack of confidence in their ability to appropriately assess a patient's functional ability to RTW and

their inability to answer every question asked on the forms seemed to cause feelings of frustration and anxiety among several of the FPs. One noted, "I never feel like I have enough information to fill out all the damn forms. All those questions—I can't answer them. So I have difficulty with that."

As a result, the FPs explained how they were very careful with what they put in writing. They expressed concern about whether they would be legally liable should anything happen to their patients as a result of something they wrote:

> I don't really know what the consequences are in terms of the legality. If I were to say, "Yeah, this person can carry 20 kg," and they go to work and carry 20 kg and something happens, I don't know what happens in that situation. I don't know if it comes back to me.

Overall, FPs cited inadequate medical education, poor preparation for determining disability, and insecurity around their ability to determine disability as contributing to the belief that filling out forms was a personal (and potentially a legal) burden.

Improving the experience

Participants offered various solutions to the challenges they faced in assessing functional ability for RTW. All FPs described a lack of knowledge regarding patients' workplaces. Some suggested that along with the forms, there could be a brief description of the workplace and a list of potential modified duties:

> It would be nice if the employer sent something to me maybe stating what this person's duties are and what they have to do, and then I would have a better idea and I would be able to say, "Well yes, I think you can do this; I think you can do that."

Others described standardizing the forms or aligning the forms to "fit" what the FP was already doing in terms of their routine assessment. Others discussed a more interprofessional approach to assessing functional ability through a partnership between the FP and a physiotherapist:

> A doctor and a physiotherapist together might be a good combination because I think they would be able to do all these things. I mean, I can't assess [everything] on my own. I wonder if a physiotherapist could be involved.

However, several FPs believed they could forgo the whole process of assessing functional ability for RTW. They believed that there were other health care professionals who were better equipped to conduct thorough assessments:

> I think having a physiotherapist or someone else who is better trained to do functional assessments [would be a better solution]. I think they are probably a better person to fill something like this out. I think my role is to make sure there isn't anything acute.

Overall, FPs suggested that more information about patients' workplaces, realigning the forms, and taking an interprofessional approach to the assessment (aside from forgoing the entire process) would improve their experience and the accuracy of the functional assessment.

DISCUSSION

Parsons' construct of the *sick role* has provided an important framework for understanding the health and illness behaviour of individuals.[29] By virtue of accepting the sick role, an individual is temporarily allowed to demonstrate dependency and is relieved of performing other roles and tasks. In return, the individual is expected to work toward getting better and to seek medical attention that facilitates their recovery. If the individual is believed to jeopardize the rights and privileges of the sick role, they can be seen as a malingerer, feigning sickness to acquire privileges accorded to the sick, or what Parsons calls *secondary gains*.[29]

Physicians are traditionally considered to be legitimate gatekeepers of entry into the sick role. According to Freidson, physicians are society's authority on what "illness really is," hence they create the social possibilities for acting sick.[30] Physicians are not only experts, but also incumbents in an officially sanctioned position in which they determine who is sick and what should be done about it. That said, physicians themselves feel frustrated with bearing the burden of imposing the final word on assessing functional ability for RTW. According to the literature, factors contributing to the difficulty of this issue for physicians include time constraints, insufficient educational opportunities about occupational health issues, possible conflicts with their role as their patients' advocates, and the complex nature of the physician-patient relationship.[16]

This study contributed new information about academic FPs experiences with assessing functional ability for RTW. The findings suggest that much work needs to be done to improve this experience and process. Although this study gathered data from a small sample, the findings resonate with the academic literature that has emerged in the area of the physician's role in assessing disability and determining sick leave.[31-33]

Through this analysis, we have learned how difficult it is for FPs to assess functional ability for RTW and about the tremendous limitations of using a single assessment form as the main pathway of communication among workplace stakeholders. This assessment form is typically used by workplace compensation boards and is often the only means of communication between the employer and the health care provider. As a communication tool, it is unidirectional and impersonal, and respondents described it as difficult to fill out accurately. According to the FPs in this study, there is a high degree of uncertainty surrounding the information they provide when filling out these forms. It is clear that such assessment forms do not adequately allow for the exchange of information fundamental to RTW assessment.

Although psychosocial factors related to RTW are important to consider, the workers' compensation system is more biomedically oriented. Family physicians are asked to provide diagnoses, prognoses, and RTW dates. For injuries in which healing processes are highly predictable, assessment forms can be easily completed. We heard from the respondents, however, that most soft-tissue injuries fail to follow a predictable pattern of recovery. Family physicians are not trained in occupational health in general, and they have little or no experience identifying and determining disability in particular. As a result, the respondents in this study often relied on information provided by their patients to complete the functional-ability forms. Our findings concur with those of Pransky et al,[17] who found that primary care providers relied mainly on patient input for disability assessment. As a result, the potential for considerable discordance often exists among the various stakeholders, particularly within the physician-patient relationship. Another study found that 80% of physicians thought that completing disability forms could adversely affect physician-patient relationships, and that 62% thought that it constituted a conflict of interest.[34] The FPs in our study described feeling troubled by the fact that they could not distinguish between malingerers and nonmalingerers. Although outright malingering seems to be the exception, distortion and some exaggeration of symptoms might be common.[35] These areas of nonmedical distress cannot be captured in a biomedically oriented functional assessment.

In essence, we heavily rely on FPs to provide medical justification for receipt of compensation benefits, to give opinions about whether injuries or illnesses are related to work, to determine the length of time workers should be off work, and to judge the appropriateness of temporary work reassignments.[2,7] However, FPs think that current medical education is not providing them with the training necessary to fill these roles. In addition, FPs are equipped with a poor communication tool—a single assessment form—and expected to assess a patient's functional abilities to RTW. It is of little surprise that many FPs feel frustrated and would prefer to forgo the process entirely.

Those involved in the RTW process need to re-examine the usefulness of these functional assessment forms to determine how they can be modified to address psychosocial components of work disability prevention. In addition, stating that communication between all stakeholders in the RTW process is important is not enough. We need to provide those involved in the process with the tools necessary to complete their tasks in a confident manner. An interprofessional approach to disability management in which there is a partnership between health professionals who are specifically trained to assess functional abilities and FPs who have specific knowledge of their injured patients would certainly help to facilitate the process.

Limitations and strengths

Caution is needed in interpreting the results of our study. As for all qualitative studies, the findings are context-bound and might not be generalizable to other FPs. The nature of this research was descriptive and exploratory, and thus cannot provide definitive conclusions; however, the findings support current literature that describes the importance of improving communication channels among workplace stakeholders. Given the current momentum for including all workplace stakeholders in the RTW process, further research is warranted in the area of improving existing communication tools and creating other innovations to assist the RTW process.

Conclusion

Family physicians play an integral role in the assessment of functional abilities for RTW. As in other areas of medicine, the role of the FP is to restore health; optimize social, psychological, and functional capabilities; and minimize the negative effects of injury. Assessing functional abilities for RTW can be challenging, as FPs are trained to focus on assessing and treating symptoms rather than on determining occupational functioning. Clearly, a functional assessment does not provide enough information for physicians and serves as a poor communication tool among the stakeholders involved with returning injured workers to work. In addition, functional assessments have not been shown to predict recovery. Given the importance of providing appropriate, timely, and specific information, it is critical for all concerned parties to reassess the usefulness of requiring a functional assessment and embrace a biopsychosocial model in the determination of readiness to RTW.

Dr Soklaridis is Research Manager for the Department of Surgery at St Michael's Hospital in Toronto, Ont, and Adjunct Professor for Lakehead University in Thunder Bay, Ont. **Ms Tang** is a medical student at the University of Hong Kong and was a summer research student at the Centre of Research Expertise in Improved Disability Outcomes (CREIDO) in Toronto at the time of the study. **Ms Cartmill** is a research assistant at CREIDO. **Dr Cassidy** is Director of CREIDO, Senior Scientist at the Toronto Western Research Institute,

and Professor at the Dalla Lana School of Public Health at the University of Toronto. **Dr Andersen** is an occupational health physician, Adjunct Professor at Lakehead University, Assistant Professor at the Northern Ontario School of Medicine, and Research Coordinator at the Northern Ontario School of Medicine Family Medicine Residency Program in Thunder Bay.

Contributors

Dr Soklaridis contributed to the development, implementation, analysis, and reporting of this study. **Ms Tang** and **Ms Cartmill** made equal contributions to the implementation, analysis, and reporting of this study. **Dr Cassidy** and **Dr Andersen** made equal contributions to the analysis and reporting of this study.

Competing interests

None declared

Correspondence

Dr Sophie Soklaridis, St Michael's Hospital, Research Manager, Department of Surgery, Li Ka Shing Knowledge Institute, 2nd Floor Shuter Wing, 30 Bond St, Toronto, ON M5B 1W8; telephone 416 864-6060, extension 77020; e-mail **soklaridiss@smh.ca**

References

1. Krause N, Frank JW, Dasinger LK, Sullivan TJ, Sinclair SJ. Determinants of duration of disability and return-to-work after work-related injury and illness: challenges for future research. *Am J Ind Med* 2001;40(4):464-84.
2. Guzman J, Yassi A, Cooper JE, Khokhar J. Return to work after occupational injury. Family physicians' perspectives on soft-tissue injuries. *Can Fam Physician* 2002;48:1912-9.
3. Canadian Medical Association. *The physician's role in helping patients return to work after an illness or injury* (update 2000). Ottawa, ON: Canadian Medical Association, 2001. Available from: **http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD01-09.pdf**. Accessed 2010 Jan 7.
4. Alberta Medical Association. *Early return to work after illness or injury*. Edmonton, AB: Alberta Medical Association; 1994. Available from: **www.albertadoctors.org/bcm/ama/ama-website.nsf/AllDocAdmin/76928055E6EB2CC487256E1B0082EE7A?OpenDocument**. Accessed 2008 Jan 15.
5. Manitoba Medical Association. *Early return to work after illness or injury: the role of the physician in RTW planning. MMA position statement.* Winnipeg, MB: Manitoba Medical Association; 1994.
6. Ontario Medical Association Committee on Medical Care and Practice. The role of the primary care physician in timely return-to-work programs. *Ont Med Rev* 1994; 61(10):19-22.
7. Reynolds CA, Wagner SL, Harder HG. Physician-stakeholder collaboration in disability management: a Canadian perspective on guidelines and expectations. *Disabil Rehabil* 2006;28(15):955-63.
8. Shaw WS, Feuerstein M, Lincoln AE, Miller VI, Wood PM. Case management services for work-related upper extremity disorders. Integrating workplace accommodation and problem solving. *AOHNJ* 2001;49(8):378-89.
9. Shaw WS, Pransky G, Fitzgerald TE. Early prognosis for low back disability: intervention strategies for health care providers. *Disabil Rehabil* 2001;23(18):815-28.
10. Dasinger LK, Krause N, Thompson PJ, Brand RJ, Rudolph L. Doctor proactive communication, return-to-work recommendation, and duration of disability after a workers' compensation low back injury. *J Occup Environ Med* 2001;43(6):515-25.
11. Englund L, Tibblin G, Svärdsudd K. Variations in sick-listing practice among male and female physicians of different specialties based on case vignettes. *Scand J Prim Health Care* 2000;18(1):48-52.
12. Roberts-Yates C. The concerns and issues of injured workers in relation to claims/injury management and rehabilitation: the need for new operational frameworks. *Disabil Rehabil* 2003;25(16):898-907.
13. Kazimirski JC. Helping patients return to work. *CMAJ* 1997;156(5):680-1.
14. Hussey S, Hoddinott P, Wilson P, Dowell J, Barbour R. Sickness certification system in the United Kingdom: qualitative study of views of general practitioners in Scotland. *BMJ* 2004;328(7431):88. Epub 2003 Dec 22.
15. Taiwo OA, Cantley L. Impairment and disability evaluation: the role of the family physician. *Am Fam Physician* 2008;77(12):1689-94.
16. Beaumont D. Rehabilitation and retention in the workplace—the interaction between general practitioners and occupational health professionals: a consensus statement. *Occup Med* (Lond) 2003;53(4):254-5.
17. Pransky G, Katz JN, Benjamin K, Himmelstein J. Improving the physician role in evaluating work ability and managing disability: a survey of primary care practitioners. *Disabil Rehabil* 2002;24(16):867-74.
18. Speziale HJ, Carpenter DR. *Qualitative research in nursing: advancing the humanistic imperative.* 4th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2007.
19. Giorgi A. The phenomenological movement and research in the human sciences. *Nurs Sci Q* 2005;18(1):75-82.
20. Patton MQ. *Qualitative research and evaluation methods*. London, UK: Sage; 2002.
21. Morse J, Field P. *Qualitative research methods for health professionals*. London, UK: Sage; 1995.
22. Pickler RH. Evaluating qualitative research studies. *J Pediatr Health Care* 2007;21(3):195-7.
23. Creswell JW. *Qualitative inquiry and research design: choosing among five traditions*. Thousand Oaks, CA: Sage; 1998.
24. Moustakas C. *Phenomenological research methods*. Thousand Oaks, CA: Sage; 1994.
25. Polkinghorne DE. Phenomenological research methods. In: Valle RS, Halling S, editors, *Existential-phenomenological perspectives in psychology*. New York, NY: Plenum; 1989. p. 41-60.
26. Boeije H. A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Qual Quant* 2004;36(4):391-409.
27. Berg BL. *Qualitative research methods for the social sciences*. 6th ed. Boston, MA: Allyn and Bacon; 2007.
28. NVivo, version 8.0 [computer software: qualitative data analysis program]. Cambridge, MA: QSR International; 2008
29. Parsons T. Illness and the role of the physician: a sociological perspective. *Am J Orthopsychiatry* 1951;21(3):452-60.
30. Friedson E. *Profession of medicine*. New York, NY: Dodd, Mead; 1970.
31. Mayhew HE, Nordlund DJ. Absenteeism certification: the physician's role. *J Fam Pract* 1988;26(6):651-5.
32. Carlsen B, Norheim OF. "What lies beneath it all?"—an interview study of GPs' attitudes to the use of guidelines. *BMC Health Serv Res* 2008;8:218.
33. O'Fallon E, Hillson S. Physician discomfort and variability with disability assessments. *J Gen Intern Med* 2005;20(9):852-4.
34. Zinn W, Furutani N. Physician perspective on the ethical aspects of disability determination. *J Gen Intern Med* 1996;11(9):525-32.
35. Ensalada LH. The importance of illness behaviour in disability management. *Occup Med* 2000;15(4):739-54.